DOCUMENT RESUME

ED 088 626 RC 007 749

AUTHOR Heiman, Elliott M.; Kahn, Marvin W.
TITLE Demographic and Symptom Characteristics of Lower Socioeconomic Patients from a Barrio Neighborhood Mental Health Service.
PUB DATE Apr 73
NOTE 18p.; Expanded version of a paper read at the Western Psychological Association Meeting, Anaheim, Calif., April 1973

EDRS PRICE MF-$0.75 HC-$1.50
DESCRIPTORS Community Surveys; *Demography; Economically Disadvantaged; Emotional Problems; Family Problems; Females; *Individual Characteristics; Medical Services; *Mental Health Programs; *Mexican Americans; Neighborhood Centers; *Patients (Persons); Personality Problems; Physical Characteristics; Program Effectiveness; Young Adults

ABSTRACT

The population surveyed consisted of all cases referred to the Social Service-Mental Health Section of the El Rio Santa Cruz Neighborhood Health Center (NHC) from June to October 1971. The NHC provides comprehensive mental health services to the predominantly Mexican American Model Cities area of Tucson, Arizona. The principal contact person at NHC--social worker, psychologist or psychiatrist--filled out an information schedule on each patient. This schedule included demographic information, social history, and the presence and intensity of certain symptoms and problem behaviors. The findings suggested that this NHC service was able to reach a high risk Mexican American population frequently missed by mental health programs, contrary to the findings of other studies. The patients seen were predominantly poor, young adult Mexican American women with marital problems, somatic complaints, and symptoms of depressions. (KM)

ED 088626

RECEIVED
MAR 15 1974
RMSU
E.R.I.C.

PRECIS

Detailed demographic and symptom data was collected over a four month period on patients seen in a mental health service which was integrated into a Neighborhood Health Center serving a predominantly Mexican American Model Cities neighborhood. The findings suggest that this service was able to reach a high risk Mexican American population frequently missed by mental health programs, contrary to the findings of other studies. The patients seen were predominantly poor, young adult Mexican American women with marital problem, somatic complaints and symptoms of depression.

U.S. DEPARTMENT OF HEALTH,
EDUCATION & WELFARE
NATIONAL INSTITUTE OF
EDUCATION
THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL NATIONAL INSTITUTE OF EDUCATION POSITION OR POLICY

RC007749

Demographic and Symptom Characteristics of Lower Socioeconomic Patients from a Barrio Neighborhood Mental Health Service

Elliott M. Heiman, M.D. and Marvin W. Kahn, Ph.D.

Neighborhood Health Centers (NHC) have been established throughout the United States to provide comprehensive health care to the poor. The El Rio Santa Cruz NHC was established in October 1970 by the Department of Family and Community Medicine at the University of Arizona College of Medicine to serve the predominantly poor Mexican American Model Cities area of Tucson.

Several articles on the provision of mental health services within an NHC (1-3) have focused on accessibility, community involvement and consultation to the health team. However, we have not as yet seen a demographic study of patients receiving mental health care within an NHC.

The patients treated by the El Rio Santa Cruz NHC are both predominantly lower socioeconomic class and Mexican American. Several epidemiologic survey studies of mental health (4-6) show greater psychopathology and inferior mental health treatment for the poor. Additional studies (7, 8) indicate a significant underutilization of mental health facilities by the Mexican Americans.

Demographic and diagnostic characteristics of persons receiving outpatient mental health services have been reported in several studies. Bahn (9), has summarized such characteristics for all outpatients in the State of Maryland, and in a somewhat later paper, Rosen, Bahn and Kramer (10) presented the same type of data for the entire United States. Thus, data exist at the national and

THIS IS AN EXPANDED VERSION OF A PAPER READ AT WESTERN PSYCHOLOGICAL ASSOCIATION MEETING, ANAHEIM, CALIFORNIA, APRIL 1973.

state levels of the characteristics of individuals receiving outpatient mental health services.

In addition, the characteristics of populations of local mental health clinics have been compared with other clinics and with data from large scale studies. In this connection McKnight et al (11) have compared the demographic characteristics of patients in their outpatient clinic to that of the entire Hartford, Connecticut area. Gannat and Lebow (12) have compared the characteristics of a northern region outpatient clinic with those of a southern region clinic.

Relatively few studies have been reported on Mexican American mental health problems and treatment. Meadow and Stoker (13) have compared Mexican American and Anglo inpatient symptom characteristics. They found that Mexican American male symptoms are characterized by alcoholism and threats of violence whereas Mexican American females tend to exhibit crying spells, irritability, depression and temper tantrums. Fabrega et al (14) have described Mexican American outpatients as often reporting somatic complaints. Men, particularly, express themselves in "somatic constructs." Burrell and Chavez (15) and Phillipus (16) have described characteristics of successful mental health treatment programs for Mexican Americans. Karno, Ross and Kaper (17) note the importance of the physician in providing mental health services to the Mexican American community. In regard to physicians, a recent study by Shepherd et al (18) in England, found that an average of 14% of the patients seen by family physicians were found to have a psychiatric disorder. We would therefore expect that an NHC that provides

total family health care would be an excellent place to identify patients, both Mexican American and non-Mexican American, who might utilize mental health treatment.

The community mental health center movement has brought into focus the importance of knowing the types and extent of mental health problems, both for the entire population and for localized areas. In order to mount effective treatment programs we must know both the population at risk and the most effective way of reaching those people who need help. This present study provides descriptive data concerning the nature of the utilization and the characteristics of the individuals who utilize a barrio mental health program. Comparison with other mental health populations are made.

METHOD

The population surveyed consisted of all cases referred to the Social Service - Mental Health Section of the El Rio Santa Cruz Neighborhood Health Center over a four month period from mid-June to mid-October, 1971.

The NHC provides comprehensive health services to the Model Cities area of Tucson which has a population base of approximately 20,000. Identification of the age and sex distribution for that Model Cities area was available. More extensive demographic data including ethnic group, marital status and source of income, was available for patients of the NHC.

The principal contact person at the NHC, the social worker, psychologist or psychiatrist, filled out a formal information schedule on each patient referred for mental health care. This schedule contained 77 items including demographic information, social history

and the presence and intensity of certain symptoms and problem behaviors. This data was summarized to present demographic and symptom characteristics of the mental health patients in terms of percentage of occurrence in the sample population. Further, where it was possible, characteristics of the mental health population was compared with the Health Center population as a whole, and with the Model Cities area population. This was done by a chi square proportional analysis.

RESULTS

A. Age-sex, ethnic origin, and other demographic factors.

As can be noted from Table I, the age distribution of the mental health cases fall largely in the range from 15-44 years (82%). Only 7% fall between 5-14 years, and no cases were seen below age 5. This age distribution differs significantly from that for the Center as a whole ($X^2 = 70.1 < .01$), where only 40% of the patients fall in the age category of 15-44 while 46% are less than 14 years of age. The Health Center as a whole saw significantly more young patients and fewer elderly patients than is represented in the Model Cities population ($X^2 = 463.94 < .01$). These age differences are consistent for both male and female patients as indicated in Table II. The Health Center saw more children and the Mental Health program saw more young to middle age adults and both saw fewer elderly patients than is represented in the base Model Cities population.

From Table III it can be noted that 73% of the Mental Health population were of Mexican American ethnic origin. The percentage of Mexican Americans for the Health Center as a whole was 83%, a significantly greater proportion. It appears that this

discrepancy is largely a function of the differences in the age distribution of the two services. The heavy concentration of young children in the Health Center population, who were almost exclusively Mexican American, appear to be the main factor in the difference.

Another significant difference between the Mental Health Program and the NHC as a whole was in the proportion of women. The Mental Health population was 77% female while the NHC population was 55% female. The proportion of women in the Model Cities area was 54%, approximately the same as for the Health Center.

It appears in our data that the Mental Health population had more persons who were divorced and had a higher percentage of individuals living on pensions rather than gaining their income from employment. However, these findings were influenced by the age variables previously noted and further evaluation is required.

In summary, the population using the Mental Health services differed from the Model Cities area and the NHC population in having a higher proportion of females, a higher proportion of young to middle-age adults and proportionately somewhat less Mexican Americans.

The social class level, as rated by the Hollingshead classification, was predominantly level 5, the lowest level on that scale. While most of the Mental Health patients, (87.7%) spoke English, 56% lived in bilingual homes. The population was a fairly stable one in terms of residency, 66% had lived in the city for more than four years and 35% had been in their same neighborhood for a comparable period. In terms of household composition 37% lived with their spouse and children while 21% lived with parents.

Forty-two per cent of the mental health patients gave a history of broken parental home with divorce and separation being

the most prominent reasons. In 45% of the cases there was a family history of psychological problems.

B. The mental health problems of the Barrio population, by sex and ethnic origin.

Table IV gives the percentages of various categories of observed symptoms and problems as rated by professionals at intake. This table provides data for the total mental health group by sex and ethnic origin. This categorization offers an opportunity to compare the symptoms, referrals and problems of Chicanos and non-Chicanos who reside in the same urban area.

It can be noted that the main reason for referral to Mental Health were depression, anxiety and family conflict. Suicide attempt was present in almost 20% of the Chicano referrals while it was not at all present in the non-Chicano referrals. Psychosis was the reason for 13.3% of the male referrals as opposed to only 4.2% of the female referrals. In general, the physician was the main source of referral. It is of note that referrals from social workers were only for non-Mexican Americans.

In terms of primary problems or symptoms observed by the professionals at intake, difficulty with spouse, physical symptoms and anxiety were the most predominant.

A variety of symptoms were judged also present in a large proportion of the Mental Health cases. These included family stresses, a variety of symptoms associated with depression including concentration disturbance, social withdrawal, loss of interest, guilt, sadness, crying spells, and feelings of worthlessness.

A difference in the proportion of occurrence of symptoms between Mexican American and non-Mexican American groups was noted on occasion. For instance, the Mexican Americans seemed to more often have primary difficulty with their spouse, whereas the non-Mexican American group more often had primary difficulty with their children. Symptoms of insomnia, suicidal ideation, crying spells, and physical complaints were more frequently present with the Chicanos whereas loss of interest was more often reported for the non-Chicano. School and work disturbances seemed to happen more often with the non-Chicanos while housekeeping disturbance and, at a low level of occurrence, drug and alcohol problems were more frequently present with the Chicanos than with the non-Chicanos.

Those behaviors and symptoms which were infrequently present in this population included sleep disturbances, weight gain and loss, sexual problems. Suicidal ideation did not often occur despite the fact that it was a frequent referral problem. Psychotic manifestations such as delusions and hallucinations, as well as drug and alcohol problems were not present to any large degree.

DISCUSSION

Of primary significance in our study is the fact that the mental health program in the NHC is clearly serving the Mexican American population of the Model Cities area. This success in reaching a population frequently missed can perhaps be understood by examining the nature of the NHC and the place of the mental health program within the NHC.

The NHC is a comprehensive family oriented health facility located visibly and accessibly in the midst of the Barrio. The center has a community board, many Spanish speaking employees, a strong outreach component, transportation and a general "helping" atmosphere. When the Center opened in October, 1970, the staff went into the community to publicize and "sell" this center. The people from the community quickly filled the center to capacity.

From the inception of the Center the philosophy of the mental health program was not to be just a place to send people with psychological problems. The mental health staff, who were located geographically within the NHC, made every effort to become a part of the total health care team, and I believe succeeded. Perhaps the one lesson to be learned from this study is that mental health services will reach the Mexican American people if they are integrated within a health facility which because of its location, its community representation and its outreach atmosphere is itself reaching the people.

The patients predominantly seen in our mental health program were women between the ages of 20 and 40 with family problems and symptoms of depression. If we look at the age and sex distribution for the diagnosis of depression in clinics across the country we see that to a great extent our program reflects the national pattern. Although we do see women who are depressed, there are certain significant groups which are prominent in the national pattern that are infrequently seen in our population. As noted in the results, among these groups are children and men.

The specific nature of a comprehensive health facility for case finding can perhaps best explain our treating so many depressed women. Shepherd in his study of psychiatric disturbances seen in the family physician's offices in England found nearly twice as many disturbed females as males. This significantly larger number of women can be explained by the fact that (1) men are less disturbed than women or (2) women are more likely to go to a family physician with their problems or perhaps, a combination of these two factors. The fact that women tend to visit their physician more often than men is corroborated in the NHC data that although women register approximately as often as males they visit the center twice as frequently.

Just as in the general Anglo culture, the Mexican American man has difficulty admitting "psychological" or "physical" weakness in coming to a doctor for help. The fact that men had to be "sicker" in order to come for help is illustrated by the large percentage of "psychotic" referrals. Although this observation is by means universal, our general impression is that women become depressed, often with physical complaints, and follow a previous pattern of turning to the doctor. The men, under similar psychological and situational stress, would tend to turn within themselves or to alcohol and drugs. We observed that many of the spouses and other male family members of our women patients have alcohol and drug problems. Further corroborating this observation is the fact that the local methadone maintenance program treating an overlapping population shows an opposite sex distribution from the mental health program at the NHC, that is, predominantly male.

The fact that we are not seeing as large a proportion of children as the national pattern again we feel is related to the NHC as a case finding agency. If we were to work with the schools and juvenile court we would quickly find many of our younger patients. The local community mental health center with its larger catchment area would be a more appropriate place for this type of case finding. Although the NHC is perhaps not the most natural portal of entry into the mental health treatment system for school age children, the health center would be an ideal place for locating and treating high risk infants and disturbed mother-child relationships in preschool children.

The general symptom and problem data will only allow us to make the most general observations. There does not appear to be any remarkable pattern of differences between Mexican American and non-Mexican American patients. The higher frequency of crying spells and suicidal ideation and attempts among Mexican Americans could perhaps be explained by the more expressive nature of the Chicano culture. The high incidence of physical symptoms among the Mexican American patients agrees with previous observations and underlines the potential effectiveness of a health facility in identifying mental health problems.

The reason that we found more Mexican Americans to have problems with spouses than non-Mexican Americans is not clear. It is apparent, however, that cultural conflict and change together with poverty exerts intense stress on the Mexican American family. This stress is undoubtedly manifested in problems with the spouse.

In conclusion, poor people tend to have a high incidence of psychological problems. A particular subgroup of the poor are women with marital problems who are attempting to raise their children without the support of a husband. Although the poor tend to use mental health outpatient facilities less than the middle class, poor Mexican Americans have a particularly significant record of under-utilization. Our data would indicate that our program is serving a high risk group who perhaps otherwise would not be receiving mental health services, that is, the poor Mexican American young to middle age adult female. However, at the same time, our study shows we are missing certain other vulnerable groups of people, such as the Mexican American child and male.

RECEIVED
APR 8 1974
NMSU
E.R.I.C.

REFERENCES

1. Scherl DS, English JT: Community mental health and comprehensive health service programs for the poor. Am J Psychiatry 125:166-1673, 1969

2. Walcott O: Function of mental health aides in a psychiatric clinic. Int J Soc Psychiatry 15:302-306, 1970

3. Lowenkopf E and Zwerling I: Psychiatric services in a neighborhood health center. Am J Psychiatry 127:92-96, 1971

4. Hollingstead O and Redlich F: Social Class and Mental Illness. New York, John Wiley and Son, 1958

5. Leighton DC, Harding, JS, Macklin, DB, et al: The Character of Danger. Basic Books, New York, 1963

6. Srole L, Langner TS, Michael S, et al: Mental health in the Metropolis. New York, McGraw-Hill, 1962

7. "New ways to meet the mental health needs of Mexican Americans." A report to the East Los Angeles Community, Presented by the Mental Health Development Commission (Welfare Planning Council: Los Angeles Region, April, 1968)

8. Karno M: The enegma of ethnicity in a psychiatric clinic. Arch Gen Psychiatry 14:516-520, 1966

9. Bahn AK, Chandler CA and Eisenberg I: Diagnostic and demographic characteristics of patients seen in outpatient psychiatric clinics for an entire state (Maryland): implications for the psychiatrist and the mental health program planner. Am J Psychiatry 117:769-778, 1961

10. Rosen BM, Bahn OK and Kramer M: Demographic and diagnostic characteristics of psychiatric clinic outpatients in the U.S.A. Am J Orthopsychiatry 34:455-468, 1964

11. McKnight RS, Reznikoff M, Mulligan WR, et al: Characteristics of patients in an adult outpatient clinic: a survey and evaluation. Am J Orthopsychiatry 4:636-642, 1966

12. Genott HG and Tebo D: Ecology of service. J Con Psychology 27:450-452, 1963

13. Meadow A and Stoker D: Symptomatic behavior of hospitalized patients. Arch Gen Psychiatry 12:267-277, 1965

14. Fabrega H, Ruhel AJ and Wallace CA: Working class Mexican Psychiatric outpatients. Arch Gen Psychiatry 16:704-712, 1967

15. Burrel G and Chavez N: Mental health outpatient centers: relevant or irrelevant to Mexican Americans. Presented at POCA'S National Meeting, New York, New York, March 15-16, 1973

16. Philippus MJ: Successful and unsuccessful approaches to mental health services for an urban Hispano American population. Am J Public Health 61:820-830, 1971

17. Karno M, Ross R and Caper R: Mental health roles of physicians in a Mexican American ommunity. Com mental health J 5:62-69, 1969

18. Shepherd, M, Cooper B, Brown, AC et al: Minor mental illness in London: some aspects of a general practice survey. Br Med J 2: 1359-1363, 1964

Table I

Age Distribution and Comparison between Mental Health, Health Center and the Model Cities Population

A. Age x Sample

Age	Mental Health	%	Neighborhood Health Center
0- 4	0	(.00)	1,457 (.16)
5-14	5	(.07)	2,822 (.30)
15-24	22	(.31)	2,041 (.22)
25-44	36	(.51)	1,671 (.18)
45-64	7	(.10)	870 (.09)
65+	1	(.01)	424 (.05)
	71		9,285

$X^2 = 70.10; p<.01$

B. Age x Sample

Age	Neighborhood Health Center	Model Cities
0-24	6,320 (.68)	10,814 (.49)
25-44	1,671 (.18)	3,940 (.18)
45-64	870 (.09)	4,706 (.21)
65+	424 (.05)	2,503 (.11)
	9,285	21,963

$X^2 = 463.94; p<.01$

Table II

Age Distribution, Sex Comparison between Mental Health, Health Center and Model Cities Population

A.

Age	Males: Age x Sample MH	%	NHC	%	Females: Age x Sample MH	%	NHC	%
0- 4	0	(.00)	745	(.18)	0	(.00)	712	(.14)
5-14	4	(.25)	1,392	(.33)	1	(.02)	1,430	(.28)
15-24	1	(.06)	898	(.22)	21	(.38)	1,143	(.22)
25-44	9	(.56)	627	(.15)	27	(.49)	1,044	(.20)
45-64	2	(.13)	324	(.08)	5	(.09)	546	(.11)
65+	0	(.00)	162	(.04)	1	(.02)	262	(.05)
	16		4,148		55		5,137	

$X^2 = 24.03$ $p < .01$

$X^2 = 68.52$ $p < .01$

B.

Age	Males: Age x Sample NHC	%	M. Cities	%	Females: Age x Sample NHC	%	M. Cities	%
0-24	3,035	(.73)	5,344	(.53)	3,285	(.64)	5,470	(.46)
25-44	627	(.15)	1,868	(.19)	1,044	(.20)	2,072	(.17)
45-64	324	(.08)	1,708	(.17)	546	(.11)	2,998	(.25)
65+	162	(.04)	1,154	(.11)	262	(.05)	1,349	(.11)
	4,148	1.00	10,074	1.00	5,137	1.00	11,889	.99

$X^2 = 747.07$ $p < .01$

$X^2 = 947.68$ $p < .01$

Table III

Ethnic Group Comparison

	MHP	NHC
Mexican American	52 (.73)	7,749 (.83)
Non-Mexican Amer.	19 (.27)	1,536 (.17)
	71	9,285

$\chi^2 = 2.22$ $p < .01$

Sex Sample

	MH	NHC	Model Cities
Male	16 (.23)	4,148 (.45)	10,074 (.46)
Female	55 (.77)	5,137 (.55)	11,889 (.54)
	71	9,285	21,963

$X^2 = 21.67$ $p < .01$